Advising the Congress on Medicare issues

Promoting the use of primary care

Cristina Boccuti and Kevin Hayes

April 9, 2008

MEDPAC

Overview

- Importance of primary care and its risk of underprovision
- 3 initiatives to promote the use of primary care in Medicare
  - Services: E/M work revaluation (March 2006)
  - ➢ Practitioners and services: fee schedule adjustment
  - ➢ Care coordination: medical home programs
- Recommendations

What is primary care and who provides it?

- Primary care
  - Comprehensive health care provided by personal clinicians who are responsible for the overall, ongoing health of their individual patients.

- Primary care providers
  - Team of physician and non-physician providers
  - Physicians, nurse practitioners and physician assistants who train in primary care fields
  - Specialists who treat patients' main chronic condition

Importance of primary care

- Americans value having a primary care physician who knows about their medical problems (Schoen 2007, Grumbach 1999).
- Increasing the use of primary care services and reducing reliance on specialty care can improve the efficiency and coordination of health care delivery without compromising quality (Fisher et al., 2003; Starfield and Shi 2002).
- Yet, primary care services are undervalued and at risk of being underprovided.

Access to primary care

- Most beneficiaries have a usual source of care that they value.
- But some access concerns exist.
  - Among those looking for a new primary care physician (<10%) 29% report some difficulty.
  - U.S. medical school graduates selecting family practice and primary care residencies has declined steadily.
  - Internal medical residents are increasingly becoming subspecialists.

Fee schedule adjustment to promote primary care

- Payable for evaluation and management services in the statutory definition of primary care:
  - Office visits
  - Home visits
  - Visits to patients in non-acute facilities
- Targeted toward generalist practitioners who mostly furnish primary care services
- Budget neutral

Recap of issues discussed at the March meeting

- Adjustment could address concerns about undervaluation of primary care
- Major departure from current structure of the fee schedule
- Level of the adjustment
  - Judgment required
  - Precedents: HPSA and scarcity bonuses

Practitioners vary in how much they furnish primary care services

Practitioner/specialty	Primary care services as a percent of practitioner/specialty allowed charges
All primary care practitioners	**50.5%**
Physician	
- Geriatric medicine	65.0
- Family practice	62.5
- Internal medicine	44.4
- Pediatric medicine	36.5
Nurse practitioner	65.4
Physician assistant	34.8
All other	**13.4**

Source: MedPAC analysis of 2006 claims data for 100 percent of Medicare beneficiaries.

MEDPAC

Two options for targeting the adjustment

- Option 1: Specialty designation + Practice focused on primary care services
  - Limit eligibility to selected practitioners
    - Physicians: Geriatric medicine, family practice, internal medicine, pediatric medicine
    - Nurse practitioners and physician assistants
  - Require a minimum threshold of allowed charges in primary care services
- Option 2: Practice focused on primary care services (only)

Requiring and verifying a focus on primary care services

- Targets the adjustment toward promoting primary care
- Addresses ambiguity in specialty designation
- Inhibits strategic behavior in self-designation of specialty

Option 1: Targeting with specialty designation and claims pattern

Issues:

- Targets generalists
- Specialty is self-designated
- Criteria needed

Option 2: Targeting with claims pattern only

Issues:

- Accommodates blended practices
- Opens eligibility for the adjustment to specialists
- Requires larger reduction for budget neutrality or a higher threshold of primary care services

Medical home programs

- General concepts, goals
  - Increase care coordination, particularly for people with multiple conditions
  - Improve efficiency of resource use
  - Enhance primary care practice and access

Essential capabilities of a medical home

In addition to providing or coordinating appropriate preventive, maintenance, and acute health services, medical homes must:

- Furnish primary care
- Use health information technology for active clinical decision support
- Conduct care management
- Maintain 24-hour patient communication and rapid access
- Keep up-to-date records of patients' advance directives
- Be accredited/certified by an external accrediting body

Beneficiary issues

- **Initial target population:** Beneficiaries with at least two qualifying chronic conditions
- **Medical home designation:** Beneficiary voluntarily selects a single medical home.
  - Signs document of medical home principles: source for comprehensive, continuous care and resource for helping patients and families navigate through the health system to select optimal treatments and providers.
  - Patients would continue to be able to see specialists without a referral from the medical home.

Beneficiary issues

- **Beneficiary education:** Medicare should engage in a public education campaign to inform beneficiaries about the benefits of primary care and medical home.
- Other implementation details
  - Qualifying medical conditions
  - Eligibility under special circumstances (e.g., nursing home residents, hospice, snowbirds)

Payment to medical homes

- Monthly payments per beneficiary for medical home infrastructure and activities
  - No beneficiary cost sharing for medical home fees
  - Medical home can continue to bill for Part B services

Pay-for-performance (P4P) component

- MedPAC has recommended that Medicare initiate physician programs to improve performance in quality and efficiency.
- Medical home pilot is an opportunity to implement and test such programs.
  - Payment incentives would be separate from the monthly fee
  - Reward based on attainment or improvement
  - Bonuses for efficiency (after a confidential feedback period) only available to medical homes that have first met quality goals
  - Incentive payments require sufficient number of patients to permit reliable comparisons.

Providing medical homes with utilization information

- To improve medical homes' understanding of patients' overall service use, Medicare could provide relevant info to medical homes.
  - Monthly reports to medical homes
  - Useful partner: Medicare administrative contractors (MACs) now processing Part A and Part B claims
  - Privacy agreements

Additional comments

- **These two policy initiatives are not meant to be mutually exclusive.**
  - *The fee schedule adjustment* focuses on primary care services provided by clinicians who predominately provide primary care.
  - *The medical home pilot* focuses on other primary care activities (e.g., care coordination).
- **Pilot must have clear and explicit thresholds for determining if it can be expanded into the full Medicare program, or discontinued entirely.**